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Prevalence of and Recovery from Common Mental Disorder including Psychotic Experiences in the UK Primary Care Improving Access to Psychological Therapies (IAPT) Programme

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Abstract

Background

Psychotic experiences (PE) may co-occur with common mental disorders (CMD), such as depression and anxiety. However, we know very little about the prevalence of and recovery from PE in primary mental health care settings, such as the Improving Access to Psychological Therapies (IAPT) services in the UK National Health Service (NHS), where most CMD are treated.

Methods

We used the Community Assessment of Psychic Experiences - Positive 15-item Scale (CAPE-P15) to determine the prevalence of PE in patients receiving treatment from IAPT services. Patient-reported measures of depression (PHQ-9) and anxiety (GAD-7) are routinely collected and establish recovery in IAPT services. We studied recovery rates according to the absence and presence of PE. Multi-group growth models estimated improvement trajectories for each group.

Results

2,042 patients with CMD completed the CAPE-P15. The mean age was 39.8. The overall prevalence of PE was 29.68%. The recovery rate was 27.43% compared to 62.08% for those without PE. Although patients with or without PE shared similar improvement trajectories, the initial severity of patients with PE impeded their likelihood of recovery.

Limitations

We mirrored routine data collection in IAPT services, including self-report questionnaires that may affect valid reporting of symptoms. Missing data in the calculation of improvement trajectories may reduce generalisability.

Conclusions

At least one in four patients receiving treatment from IAPT services in primary care experience CMD and PE. This significant group of people experience a lower recovery rate, with adverse implications not only for them but also for efficiency of services.

Keywords

Anxiety, at-risk mental state, common mental disorder, depression, prevalence, psychotic experience, psychosis, recovery.

Introduction

Psychotic experiences (PE) such as attenuated paranoid beliefs or voice hallucinations are relatively common in the general population, especially amongst young people (Linscott and van Os, 2013). Systematic reviews and evidence synthesis indicate that, viewed from a secondary-care perspective, approximately one third of people with at risk mental states for psychosis, mostly characterised by intense and frequent attenuated psychotic symptoms, will transition to a psychotic disorder (Fusar-Poli et al., 2012; Addington et al. 2011). Research in non-specialised services, such as primary care settings, has shown that far fewer (~10%) make such a conversion (Hui et al. 2013; Perez et al. 2017).

PE predict propensity to seek treatment from mental health services (DeVylder et al., 2014) and are also linked to the presence of other, non-psychotic common mental disorders (CMD), particularly depression and anxiety (Wigman et al., 2012; Hui et al., 2013). Population studies of adolescents and young people modelling the co-occurrence of depression, anxiety and PE have found that all three shared an underlying unitary psychopathological factor, i.e. common mental distress, with PE emerging towards its more severe end (Stochl et al., 2015). Thus, PE may not only act as a specific risk factor for developing psychosis; they may also act as a maker for mental ill-health more generally, indicating clinical severity and increased likelihood of co-morbidity, suicidality and poorer treatment outcomes (Healy et al., 2019; Yates et al., 2019; Cederlöf at al., 2018; Hui et al. 2013; Kelleher et al. 2012; Perez et al. 2017; Wigman et al. 2014).

Research examining the impact of PE has predominantly been conducted in specialised secondary mental health services designed to support those with an at-risk mental state (Wigman et al, 2012; Lin et al, 2015), or, conversely, in population samples (Varghese et al., 2011). Much less is known about the prevalence and impact of PE in primary mental

healthcare services, where most CMD are treated. One example of primary mental health care in England is the Improving Access to Psychological Therapies (IAPT) Programme (https://www.england.nhs.uk/mental-health/adults/iapt/). The IAPT programme was designed to make evidence-based psychological therapies for mild to moderate depression and anxiety disorders, collectively termed CMD, more widely available in the National Health Service (NHS) in England.

Although IAPT is commissioned to deliver talking therapies for mild to moderate CMD, they serve a clinical population with increasingly complex and co-morbid conditions (Hepgul et al., 2016; Buckman et al., 2018; Goddard et al., 2015). Given the co-occurrence of PE with depression and anxiety, and evidence that PE index severity in these disorders (Stochl et al., 2015), it is reasonable to hypothesise that a proportion of IAPT patients will experience psychotic phenomena.

Currently, the IAPT programme neither screens for, nor offers specific treatment for PE. Treatment protocols that focus exclusively on mood disturbance, leaving PE undetected and untreated may potentially exacerbate depression and anxiety. Such complexity and co-morbidity suggest that a significant minority of patients in IAPT services would be managed sub-optimally by the standard interventions for CMD the services are designed to deliver.

To understand the potential prevalence and impact of PE on meeting service-level thresholds defining recovery from depression and anxiety in IAPT services, we conducted an exploratory evaluation in two IAPT teams in Cambridgeshire and Peterborough NHS Foundation Trust (Perez et al., 2017) using the current, 15-item version of the Community Assessment of Psychic Experiences (CAPE-P15; Capra et al., 2017). Results revealed that a higher prevalence of PEs was associated with higher depression and anxiety scores both at therapy outset and during the initial period of therapy. This period is considered a predictor of potential full recovery in the IAPT setting (Delgadillo et al., 2014).

This evaluation was the first to measure PE in the IAPT population and suggested that a significant proportion of patients accessing IAPT services experience CMD including PEs (CMD-P), and are less likely to recover following therapy. However, this study was limited both in sample size and diversity, reducing the applicability of the findings to larger and more diverse IAPT populations. In addition, the statistical technique applied in this study was latent class analysis which categorised individuals as experiencing CMD-PE based on the probability of responses; therefore, a 30% prevalence of CMD-P may be an over-estimation. Furthermore, estimations of recovery were based on the response to the initial period of therapy rather than on recovery rates calculated as per national IAPT reporting at the end of therapy (Health and Social Care Information Centre: https://www.nhs.uk/Scorecard/Pages/IndicatorFacts.aspx?MetricId=6228). The current study aimed to address these limitations by 1) replicating data collection on a larger and more diverse population treated within the IAPT programme, 2) using recently established CAPE-P15 cut-off thresholds to detect PE in primary care (Bukenaite et al., 2017), and 3) comparing recovery rates between patients with CMD including PE and those without such experiences at the end of therapy in IAPT services.

Methods

Setting

The IAPT programme in England began in 2008 with a direct objective to improve access to evidence-based psychological treatment for CMD. It aimed to increase public access to National Institute for Health and Care Excellence (NICE) approved psychological therapies by offering flexible referral routes including self-referral and defining care pathways via a stepped care model. The programme has continued to expand over time and currently assesses over 1,300,000 people with CMD annually, delivering therapy to approximately

550,000. NHS England has committed to further expansion of the programme, aiming to see 1.9 million patients annually by 2024 (Clark, 2019). IAPT provides treatment for CMD for people aged 17-65 years. Cognitive–behavioural therapy (CBT) is the predominant approach adopted by these services, although there is a wider range of recommended treatments (e.g. counselling, couples therapy, interpersonal therapy or brief psychodynamic) particularly for depression. The number of sessions can vary between 8 and 20, although patients with more severe CMD receive an average of 12 over a period of 3-4 months.

Measures

The IAPT programme stipulates a minimum dataset, which records the clinical care offered to each patient and their clinical progress, via patient-reported outcome measures of depression and anxiety, i.e. The Patient Health Questionnaire (PHQ-9) (Kroenke, Spitzer, & Williams, 2001) and Generalized Anxiety Disorder questionnaire (GAD-7) (Spitzer, Kroenke, Williams, & Löwe, 2006). These measures are completed during triage, assessment and at each subsequent treatment session, ensuring that each patient has a clinical endpoint, even if they leave treatment unexpectedly. Services store this data using one of two patient management systems (PCMIS: https://www.york.ac.uk/healthsciences/pc-mis/ or IAPTUS: https://iaptus.co.uk/) and use the information to establish recovery from depression and anxiety. Several improvement metrics are used, including the recovery index (Gyani et al., 2013). This states that a patient has recovered if they score above the clinical cut-off on PHQ-9 and/or GAD-7 at outset of treatment, and below the cut-off for both the PHQ-9 and GAD-7 post-treatment, i.e. below 10 and 8 respectively. Nationally, 51% of patients accessing IAPT recover (Clark et al, 2018), although outcomes vary significantly across England. Reasons for such variation have been attributed to organisational factors such as waiting times, social deprivation, fidelity to a therapeutic model, dose responses effects and

variation in the clinical complexity of patients seen across services (Clark et al. 2018; Gyani et al. 2013 Delgadillo et al. 2014).

Our participating IAPT services also collected the current CAPE-P15. This is 15-item self-report measure of experiences similar to positive psychotic symptoms, grouped into three dimensions; "delusional ideation", "bizarre experiences" and "perceptual abnormalities" (See Table 1) and experienced within the past three months. It includes two 4-point Likert scales: one to indicate frequency and one to indicate distress associated with the experience. It provides a mean per-item score on both subscales, with higher scores indicating a higher frequency of PE and an increased level of distress associated with these experiences (Capra et al., 2013). Previous work (Bukenaite et al., 2017) recommended a cut-off of 1.47 for both subscales of the CAPE-P15 in order to identify clinically significant PE. This cut-off was calibrated against the Comprehensive Assessment of At-Risk States (CAARMS) (Yung et al., 2005) which identifies individuals with at-risk mental states for psychosis (ARMS). The feasibility and acceptability of this self-report questionnaire to identify these individuals in IAPT settings have already been confirmed (Perez et al., 2017).

-- Table 1 about here –

Sample

The analysis was conducted on a sample of patients who were eligible for treatment under the Improving Access to Psychological Therapies (IAPT) programme across three mental health Trusts in England: Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), Norfolk and Suffolk NHS Foundation Trust (NSFT) and Sussex Partnership NHS Foundation Trust (SPFT). Services in these trusts cover a wide and heterogeneous geographical area with

a total population of more than 4 million people living in diverse socioeconomic conditions, including urban, suburban and highly dispersed rural communities such as Fenland. Of 321 English local authority districts, those involved range from most deprived (Hastings, Sussex) to least deprived (South Cambridgeshire, Cambridgeshire) (https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019).

Data from the entire IAPT caseload of each Trust receiving services between February and December 2018 were included in analysis. For calculation of prevalence, the caseload was defined as all patients receiving treatment between the commencement and end of CAPE-P15 collection (February – December 2018). Regardless of when each patient completed the CAPE-P15, we obtained recovery data from their initial session up until their end of care date.

All patients who were accepted for treatment under the IAPT programme across the three participating mental health Trusts were eligible to complete the CAPE-P15 questionnaire. IAPT therapists in CPFT and SPFT offered the CAPE-P15 to patients during a treatment session or to complete at home between sessions. NSFT collect all routine clinical data remotely using a digital portal, links to which are automatically sent out to patients by the service. Patients were informed that completing the CAPE-P15 was voluntary. Participants were only required to complete a CAPE-P15 once during a course of therapy, at any time point determined appropriate by the therapist. It was accompanied by a short explanation of the evaluation and instructions for completion.

This study was approved by and registered with the official NHS Quality Improvement Programmes of all participating mental health NHS trusts, and confirmed as such by the UK Health Research Authority (https://www.hra.nhs.uk/). Data analysis followed

the guidelines established by the UK Anonymisation Standard for Publishing Health and Social Care Data (https://digital.nhs.uk/).

Statistical Analysis

We compared sociodemographic information between patients who completed a CAPE-P15, and those who did not. Comparisons were made using *t*-test for continuous variables and chi-square test for categorical variables.

Prevalence and recovery rates are presented separately for CAPE-P15 positive and negative patients, as determined by the cut-off of 1.47 for both subscales of the CAPE-P15 (See Measures, above). The service caseload comprises patients who had at least two treatment sessions (excluding triage sessions) with the IAPT service and at least one appointment after completing a CAPE-P15. Recovery rates were calculated for patients who had been discharged from the service and had at least one appointment after completing a CAPE-P15, using the recovery index (Gyani et al., 2013).

Multigroup growth modelling (where groups were CAPE-P15 positive and negative patients) estimated improvement trajectories for each group. This modelling approach fits a non-linear trend to the repeated measures of outcomes (total scores of PHQ-9 and GAD-7 over the course of therapy) for each patient. A subsample of n=1,149 patients from CPFT and SPFT were used in this analysis as required information on appointment number was not available in NSFT data. This analysis was conducted in MPlus version 8.2 (Muthén & Muthén, 1998-2019).

Results

Two thousand and forty-two CAPE-P15s were collected from 28, 852 patients receiving IAPT treatment during the data collection period; this was 7% of the caseload.

Participant sociodemographic characteristics

Table 2 provides a comparison of age, sex and ethnicity for patients who did and did not complete a CAPE-P15.

As the sample was a proportion of the caseload, analyses were conducted to ascertain any differences between patients who did and did not complete a CAPE-P15. The mean age of patients who completed a CAPE-P15 was 39.8 (SD=15.34) and 39.2 (SD=15.25) for patients who did not complete a CAPE-P15. There was no significant difference in age between patients who did and did not complete a CAPE-P15 ($t = 1.8127$, $df = 2351.1$, $p = 0.07$). A higher percentage (68.9%) of women completed the CAPE-P15 than men (31%). However, this sex difference was not significant when comparing the patients who did and did not complete a CAPE-P15 ($X^2 = 1.0206$, $df = 1$, $p = 0.3124$). Table 2 reveals that the majority of patients in this IAPT sample were white. The difference in ethnicity between the patients who did and did not complete a CAPE-P15 was not significant ($X^2 = 12.225$, $df = 6$, $p = 0.06$).

-- Table 2 about here –

Prevalence of psychotic experiences

Table 3 shows the number of CAPE-P15 assessments collected from patients receiving treatment in an IAPT in the 3 mental health trusts. The prevalence of CAPE-P15 positive patients was between 22 and 35 percent.

-- Table 3 about here --

Recovery rates

Table 4 compares the rates of recovery between CAPE-P15 positive and negative patients. This demonstrates that the recovery rates for CAPE-P15 negative patients fall within the nationally reported range for recovery in the 3 participating trusts. The percentage of patients reaching recovery at discharge was noticeably lower for CAPE-P15 positive patients (21% - 39%) across all 3 trusts when compared to CAPE-P15 negative patients (48% - 71%).

-- Table 4 about here –

Improvement trajectories

Figure 1 provides the mean improvement trajectories for CAPE-P15 positive and negative patients for both PHQ-9 and GAD-7. The initial severity for CAPE positive patients was much higher than for CAPE negative patients for both PHQ-9 and GAD-7, with CAPE-P15 positive patients on average beginning therapy with scores of 17.5 and 15.5 compared to CAPE- P15 negative patients who entered treatment with scores of approximately 13 and 12 on PHQ-9 and GAD-7 respectively.

Interestingly, the improvement rates (trajectory slopes) are similar for both groups. However, patients with PE require many more sessions to reach the threshold for recovery (on average) compared to those without. The difference between CAPE-P15 positive and negative patients in mean number of appointments required to reach recovery was greater for PHQ-9 than for GAD-7. CAPE-P15 negative patients required on average 6 sessions compared to 17 sessions for CAPE-P15 positive patients to reach recovery on PHQ-9. On GAD-7, CAPE-P15 negative patients required 10 sessions to reach recovery; CAPE-P15 positive patients did not reach recovery at 20 sessions.

--Figure 1 about here--

Discussion

Our study confirmed the results of a previous, exploratory evaluation (Perez et al., 2017), demonstrating the presence of PE in an IAPT sample. It also established that patients with CMD-P were less likely to recover by the end of treatment.

Using a cut-off score of 1.47 on the CAPE-P15, indicative of symptom severity comparable to those observed in individuals at risk of developing psychosis (Bukenaite et al., 2017), this study found that approximately 1 in 4 patients receiving IAPT treatment reported PE. Of these patients, only a third had recovered by the end of treatment.

Patients with depression and/or anxiety with the presence of PE began their course of treatment with IAPT with higher scores on both the PHQ-9 and GAD-7 measures, confirming that this group of patients enter the service with more severe symptoms of CMD. Although this group of patients showed a reduction in their depression and anxiety scores across sessions, their improvement trajectories were insufficiently steep to reach recovery, even after receiving twice the number of sessions that were necessary for recovery in patients without PE.

IAPT services are limited in terms of the number of sessions; the number offered varies between eight and twenty depending on the service, treatment modality and presenting problem (The National Collaborating Centre for Mental Health, 2018). Therefore, simply increasing the total number of sessions for patients with PE until they reach recovery is not feasible within the remit of the service. Given that initial symptom severity predicts the likelihood of recovery, with more severe patients needing greater improvements to drop below the caseness threshold than those with moderate symptomology, recovery over a

limited number of sessions may appear unobtainable. However, evidence suggests that patients with more severe symptoms may benefit more from therapy than those with moderate or mild symptoms. In a sample of IAPT patients, analysis of mean change scores showed the greatest improvements were found in patients entering therapy with higher scores (Gyani et al. 2013).

To be effective, treatments with this group of patients would need to deliver a steeper improvement trajectory to maximise improvement in symptoms pre- and post-therapy. Currently, IAPT services do not routinely measure PE or offer specific treatment for patients who have them in addition to depression and anxiety. Therefore, the specific therapeutic approaches needed to treat this large but under-served group are missing. Effective NICE recommended psychological treatments for patients with depression and anxiety with PE do exist but are not currently included in IAPT treatment protocols. Examples include CBT for at-risk mental states (French & Morrison, 2004), a cognitive-behavioural therapy which can effectively delay and prevent the transition to a first episode of psychosis (van der Gaag et al., 2019). Whilst individuals with a psychotic disorder interpret their symptoms as reality, those with an at-risk mental state experience less delusional certainty and are receptive to multiple explanations for their symptoms. CBT for this group aims to normalise unusual experiences and generate non-delusional interpretations of such experiences using psychoeducation, whilst preventing the consolidation of delusional beliefs by circumventing avoidance behaviours.

Co-morbidity with depression and anxiety is common amongst patients with an at-risk mental state, possibly related to delusional uncertainty where symptoms are understood as perceptual abnormalities rather than reality; simply put, the fear of losing one's mind. However, CBT for ARMS places prevention of transition to psychosis as the primary outcome, with a consequent reduction in depression and anxiety. To be eligible for treatment

in IAPT services, the presenting difficulty for a patient must be either depression, anxiety or a stress-related disorder, and recovery is based on indices of depression and anxiety. Treatment therefore must focus on these disorders; patients in IAPT with PE will likely have treatment goals closely aligned to their CMD but focusing on mood disturbance alone leaves PE untreated and potentially exacerbates depression and anxiety.

This study represents an important work stream of a wider, innovative UK National Institute for Health Research (NIHR) Programme Grant for Applied Research (TYPPEX; https://www.nihr.ac.uk/news/innovative-mental-health-study-launches-in-eastern-region/6931), where we propose that by reconfiguring existing treatment protocols for both CMD and at-risk mental states, prospects for recovery in these patients could be greatly improved. Identifying PE, understanding how they contribute to a patient's clinical presentation and integrating techniques into existing IAPT CBT treatment would provide a tailored therapy that would better meet individual needs and address CMD-P, rather than treating individual difficulties in isolation. Drawing on the existing skills of trained CBT therapists in IAPT and upskilling them with techniques to address PE would allow treatment to be tailored to the individual and assist the therapist to work with complex presentations and multiple symptoms in a systematic manner.

Limitations

Despite the originality of this study and the knowledge it adds to the literature about the prevalence of PE and impact of PE on recovery rates in primary mental health services, several limitations should be considered when interpreting the findings. First, the administering of the CAPE-P15 was not mandatory. This resulted in CAPE-P15 data being obtained for a limited proportion of the caseload. In addition, in CPFT and SPFT therapists could exercise discretion when asking patients to complete a CAPE-P15. However, in NSFT

the CAPE-P15 was automatically distributed to new patients via email, eliminating selection bias at this site. A concern was that therapists in CPFT and SPFT selected more complex patients in order to help with an understanding of the patient's presentation, potentially inflating the prevalence of PE in these services' caseloads. However, the highest prevalence was observed in NSFT where the CAPE-P15 was distributed electronically to all new patients during the collection period (see Table 3). Recovery outcomes were similar across all three sites. In addition, no basic sociodemographic difference was found between those who completed the CAPE-P15 and those who did not across sites. Second, the over and under reporting of symptoms using self-report questionnaires is well documented. Using a self-report instrument to measure PE could overestimate the prevalence because, unlike semi-structured interviews or clinical assessments, they do not allow for questioning to ensure that the experiences described are valid and questions have not been misunderstood. Differences between the prevalence of psychotic experiences measured by semi-structured interviews and self-reported experiences have been as high as 55% (5% & 60% respectively (Zammit et al., 2013). Conversely, social desirability and stigma may prevent patients from reporting PE. Nonetheless, prior evidence supports the validity of the CAPE-P15 to measure PE accurately (Mark & Toulopoulou, 2016; Núñez et al., 2015). Third, the estimated improvement trajectories were calculated for CPFT and SFPT only, as crucial information (appointment number) needed for the calculation was missing from the NSFT data. Finally, the 1.47 cut-off threshold was calculated using a measure which identifies an ARMS population (Bukenaite et al., 2017); therefore it may be too high to identify all patients with CMD and PE accessing primary care. Increasing the CAPE-P15's sensitivity by reducing this threshold might capture those experiencing fewer and/or less intense PE but higher CMD severity and, therefore, prone to poorer outcomes (Stochl et al. 2015). Future research should investigate whether increasing the sensitivity of the CAPE-P15 may offer a useful choice of cut-off values to

identify more people with PE and facilitate prompt access to more specific, evidence-based interventions.

Conclusion

At least 1 in 4 patients receiving treatment from IAPT services may suffer from PE in addition to CMD. This group of patients enter therapy with a more severe episode of CMD and are much less likely to recover by the end of treatment. Although improvement trajectories for this group showed improvement over sessions, remittance of symptoms was insufficient to meet national standards of IAPT recovery. We conclude that current psychological interventions in this service configuration are limited in their effectiveness with those population experiencing PE and CMD.

Author Contributions

Authors CK, DR, JS, TC, PBJ and JP designed the study. Authors CK, DR and JP wrote the first draft of the manuscript. DF, NG and NR were principal investigators for SPFT and NSFT. Author JS undertook the statistical analysis, had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. All authors reviewed and approved the final version of the manuscript.

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Conflicts of Interest Disclosures

JS discloses consultancy for IESO digital health. The remaining authors have no conflicts of interest to disclose.

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Table 1. The current CAPE-P15 – 15 questions, three subscales

Subscales	Questions
Persecutory ideation	1. . . . felt as if people seem to drop hints about you or say things with a double meaning?†
	2. . . . felt as if some people are not what they seem to be?
	3. . . . felt that you are being persecuted in anyway?
	4. . . . felt as if there is a conspiracy against you?
	5. . . . felt that people look at you oddly because of your appearance?
Bizarre experiences	6. . . . felt as if electrical devices such as computers can influence the way you think?
	7. . . . felt as if the thoughts in your head are being taken away from you?
	8. . . . felt as if the thoughts in your head are not your own?
	9. . . . ever been so vivid that you were worried other people would hear them?
	10. . . . heard your thoughts being echoed back at you?
	11. . . . felt as if you are under the control of some force or power other than yourself?
	12. . . . felt as if a double has taken the place of a family member, friend or acquaintance?
Perceptual abnormalities	13. . . . heard voices when you are alone?
	14. . . . heard voiced talking to each other when you are alone?
	15. . . . seen objects, people or animals that other people can't see?

†All questions 'In the past 3 months, have you .. . .'

Table 2. Comparison of age, sex and ethnicity for patients who did and did not complete a CAPE-P15.

	CAPE-P15 Status	Positive %	Negative %	None %
Age	17	6.4	2.8	2.7
	18 – 35	47.8	38.8	46.3
	36 – 64	44.1	50.8	44.4
	65+	1.7	7.6	6.6
Sex	Male	29.2	32.5	32.2
	Female	70.8	67.5	67.8
Ethnicity	Asian/Asian British	1.8	1.4	1.4
	Black/African/Caribbean/Black British	0.8	0.8	0.7
	Mixed/Multiple ethnic groups	1.8	0.7	1.4
	Mixed Other	0.8	0.2	0.4
	Not stated/not known	8.8	6.4	6.2
	Other ethnic group	0.8	0.3	0.5
	White	85.2	90.2	89.4

Site	CAPE-P15 assessments	CAPE-P15 positive	CAPE-P15 negative
CPFT	590	22.5% (133)	77.5% (457)
NSFT	1073	34.8% (373)	65.2% (700)
SPFT	379	26.4% (100)	73.6% (279)
All sites	2042	29.7% (606)	70.3% (1436)

Table 3. Prevalence of psychotic experiences across the three IAPT services.

Table 4. Recovery rates for patients with and without psychotic experiences across the three IAPT services.

Site	Status at discharge	CAPE-P15 positive	CAPE-P15 negative
CPFT	Not recovered	68.8% (77)	39.3%(132)
	Recovered	31.2% (35)	60.7% (204)
NSFT	Not recovered	78.9% (131)	51.8% (129)
	Recovered	21.1% (35)	48.2% (120)
SPFT	Not recovered	61.4% (43)	29.1% (50)
	Recovered	38.6% (27)	70.9% (122)
All sites	Not recovered	72.1% (251)	41.1 (311)
	Recovered	27.9% (97)	58.9 (446)

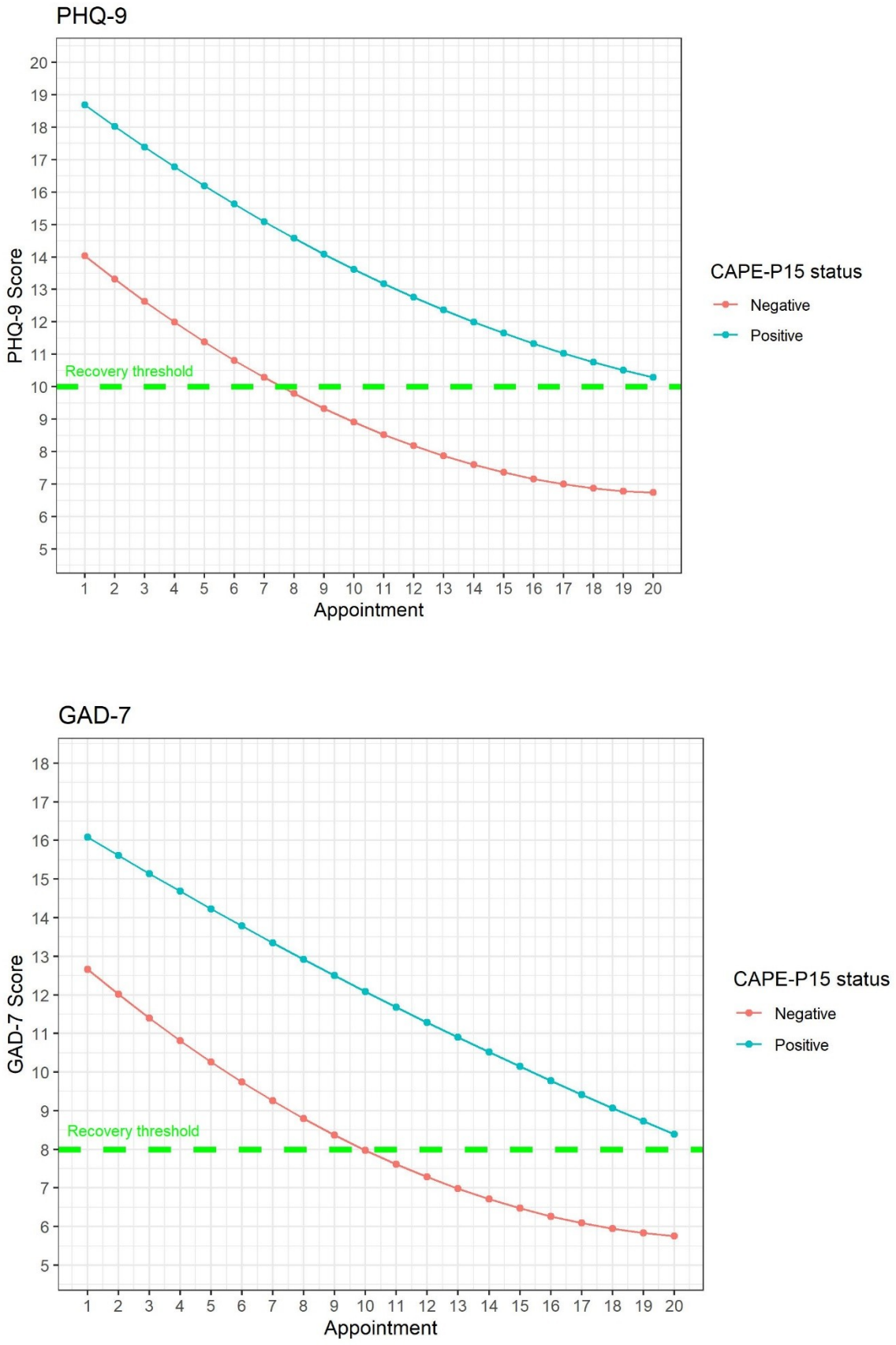

Figure 1. Trajectories of improvement for patients with and without psychotic experiences for PHQ-9 and GAD-7